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ABSTRACT

This guide from Iowa is intended to: clarify changes in the state's new rules on special education; make the state's definition of mental disability operational; provide practical guidelines on preferred practices for determination of mental disability and the need for special education services; and highlight prescriptive assessment practices tied to improved individual performance. Section 1 offers an historical perspective on philosophical changes in service delivery for individuals with mental disabilities and discusses mental disability classification in Iowa. Section 2 reviews the identification process, provides guidelines for general education intervention, and identifies the components of a full and individual evaluation. Section 3 presents general considerations concerning assessment methods and addresses multicultural issues. Section 4 provides the state definition of mental disability, examines the conceptual framework of each component of this definition, and notes considerations, recommendations, and eligibility criteria for each component. Section 5 establishes the criteria for entitlement to special education services in Iowa. Finally, Section 6 contains appendices that include a list of adaptive behavior skill areas and a glossary of terms. (Contains 33 references.) (DB)

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ASSESSMENT AND DECISION MAKING

Technical Assistance Guide for Mental Disability

BRUETT

Mental Disability Study Group
Iowa Department of Education
Bureau of Special Education
April 1997

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EC 306 329

Assessment and Decision Making for Special Education Entitlement

Technical Assistance Guide for Mental Disability

Mental Disability Study Group
Bureau of Special Education
Iowa Department of Education

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We also thank our facilitator, Ginna Booth, who kept us going during the tough times when we, as a group, were reluctant to decide on issues we were discussing. Thanks to you, we were able to complete our task in a timely fashion.

—MD Study Committee

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I. INTRODUCTION

Development of the Technical Assistance Guidelines

The passage of the new Iowa Administrative Rules of Special Education (1995) provided a timely opportunity to update the operational criteria for the identification of individuals with mental disabilities. In order to evaluate these criteria, consultants from the Iowa Department of Education, Bureau of Special Education, initiated a project to develop technical assistance guidelines. The overall purpose of these guidelines is to serve as a resource for multidisciplinary teams who use the mental disability designation. In meeting this purpose, the guide was designed to address four primary objectives:

1) To clarify changes in the new rules of special education.

2) To operationalize the Iowa definition of mental disability, which was taken verbatim from the federal definition of mental retardation.

3) To provide practical guidelines on preferred practices for the determination of mental disability and the need for special education services.

4) To highlight prescriptive assessment practices that lead to improved individual performance.

Development of the technical assistance guidelines was the result of a yearlong collaborative effort by a study group. During the 1995-1996 school year, participants in the study group met on a monthly basis to provide input on content for the guidelines. Meetings were facilitated by Ginna Booth, who provided guidance for discussions and assisted the group in clarifying decisions and recommendations. Activities during these meetings consisted of a repeating cycle of research, discussion, outline, and review. The technical assistance guidelines document is the end result of this process and represents a consensus of this group with respect to content.

Overview of the Technical Assistance Guidelines

The technical assistance guide is divided into the following seven sections:

Section I provides a brief historical perspective on philosophical changes in service delivery for individuals with mental disabilities and discusses mental disability classification in Iowa.

Section II discusses the identification process and provides guidelines for general education intervention and the components of a full and individual evaluation.

Section III presents general considerations with respect to assessment methods and discusses a selection of multicultural issues.

Section IV provides the definition of mental disability as set forth in the *Iowa Administrative Rules of Special Education* (1995), examines the conceptual framework of each component of this definition, and highlights considerations, recommendations, and eligibility criteria for each component.

Section V establishes the criteria for entitlement to special education services in Iowa.

Section VI is an appendices that includes a reference list, a list of the American Association on Mental Retardation-AAMR (1992) adaptive behavior skill areas, and a glossary of terms that are used throughout this document.

The technical assistance guidelines are not intended as a diagnostic cookbook, but rather as a resource for quality practices that facilitate the direct linkage of assessment procedures to effective interventions, services, and supports. In addition, the guide represents a record of improvements and efforts to meet the educational needs of children and youth in Iowa.

I. HISTORICAL PERSPECTIVE

Changing Paradigms in Service Delivery Systems

The field of mental retardation has undergone dramatic changes in the 20th century. These changes have been characterized as a shift in paradigms, with resultant changes in societal responses to persons with disabilities. A fundamental outcome of these shifts is the manner in which service delivery systems are organized and implemented. Paradigms for the provision of services for individuals with mental retardation have been described as facility-based, services-based, and supports-based (Polloway, Smith, Patton, & Smith, 1996). The following section provides a brief discussion of these paradigms and their implications for professional practices.

Programs for persons with developmental disabilities during the early to middle 1900s have been described as a facility-based paradigm. The underlying assumption behind this paradigm was that an individual's needs could best be met if he, or she, was grouped with others who were similarly diagnosed. The outcome of this approach was the development of institutions such as state schools and residential centers. Although this period had strong advocates for deinstitutionalization, there was considerable concern that community-based programs would be inadequate for persons with special needs.

Throughout this period there were considerable changes in the way in which mental retardation was defined and assessed. Prior to the early 1900s, definitions of mental retardation emphasized social competence, social norms, and adaptability to the environment (Harrison & Robinson, 1995). The development of the intelligence quotient (IQ) test by Binet and Simon in 1905 propelled the movement of using psychometric measures to define mental retardation and a deemphasis on adaptive skills and social competence. However, by the mid-1900s, professionals in the field called for a return to adaptive behaviors as a critical component in the diagnosis of mental retardation. This concern was reflected in the American Association of Mental Deficiency (AAMD) classification of mental retardation, which stipulated the presence of deficits in adaptive behavior as a criterion (Heber, 1961).

During the middle of the century, the emergence of a services-based paradigm drew attention to the inequalities evident in facility-based programs. This change was driven by public exposure to the poor quality of many custodial institutions, as well as a philosophical change in desirable outcomes for persons with mental retardation. A primary assumption behind this shift was that appropriate programming for individuals with developmental disabilities would prepare students for successful integration into community settings (Polloway, et al., 1996). During the early 1970s, implementation of services-based programs led to the now familiar special education classrooms, sheltered employment workshops, and community residential centers.

Throughout this period, IQ test scores continued to be used as the primary criterion in special education decision making about mental retardation (Reschly & Ward, 1991). This period also saw the advent of litigation with respect to the use of IQ scores and the overrepresentation of minority children in special education classes (Larry P. v. Riles, 1972; Marshall v. Georgia, 1984). In many cases, this litigation caused a serious reevaluation of using IQ tests as the primary indicator of mental retardation. Concurrently, the importance of adaptive behavior in defining mental retardation was reestablished. As a result, the Education for all Handicapped Children Act (1975) adopted the AAMD definition of mental retardation which included the identification of deficits in adaptive behavior as well as below average intelligence (Heber, 1961).

The last decade has seen a gradual movement toward a supports-based paradigm. This shift has been described as a move away from a deficit (within the person) orientation towards an outcome-based orientation that emphasizes the social and community roles of persons with mental retardation (Greenspan, 1995). Fundamental assertions behind this model are that individuals should be maintained and supported in inclusive settings to ensure successful learning, work experiences, and adjustment to the demands of community living. A primary example of this change in philosophy is evident in the American Association on Mental Retardation (AAMR) (Luckasson, et al., 1992) document which emphasized "level of supports" (intermittent, limited, extensive, pervasive) as a description of the needs of individuals instead of previous "level of disability" classification schemes (mild, moderate, severe, profound mental retardation). With respect to schools, a support-based paradigm is congruent with the position that special education is a **set of services** brought to natural environments rather than a **set of places** where services are provided.

Proponents for a more supports-based orientation have emphasized the opportunity for greater flexibility in diagnosing and classifying mental retardation, particularly for individuals who are assessed at the upper levels of traditional cutoff scores (Greenspan, 1995). However, others caution that this approach may promote an overemphasis on clinical judgment, rather than empirical sources for decision making, and cite the lack of research and instrumentation to support AAMR (1992) adaptive behavior domains (Gresham, MacMillan & Siperstein, 1995; Matson, 1995; MacMillan, Gresham, & Siperstein, 1993). Paradigm shifts are inevitably accompanied by intense discussion and debate. This is appropriate, since subsequent changes in public policy as a result of these shifts may have profound implications for millions of citizens (Polloway, et al., 1996).

Assessment of Mental Disability in Iowa

There are a series of important rationales underlying the current shift in the criteria for identifying mental disabilities in Iowa. Three critical issues debated by the task force included:

1) Most individuals with measured intellectual functioning in the 75-85 range do not meet the current definition of mental retardation put forth by the AAMR. Particularly, many persons with measured intellectual performance in this range do not manifest significant problems in overall life functioning. Indeed, many persons with intellectual functioning in this range are not identified as having a disability until they are challenged by the academic demands of school. Most of these individuals do not have organic disabilities and would not be identified as having disabilities in other cultures or if they were to move to a different state where identification criteria are more restrictive. In short, persons with intellectual functioning in this range often do not meet the omnibus criteria for mental retardation.

   More specifically, changes in conceptualization of mental retardation over time, as described in this section of the document caused the committee to reexamine Iowa's definition of "mental disability" in the context of the new definitions. The newer definitions in general have increased focus on supports needed to participate meaningfully in an individual's life environments. Thus, measuring and demonstrating significant and pervasive deficits in adaptive behavior and the collateral supports needed by the individual have become more important to documenting the presence of mental retardation. Additionally, the importance of relying heavily on an "IQ score" has collaterally decreased. Significant and pervasive deficits in adaptive behavior are much less likely to occur with persons

whose intellectual performance is in the range of 75-85 than for persons with significantly lower measured intellectual performance. Thus, given these new identification criteria for mental retardation, many persons with intellectual performance in this range would not meet the adaptive behavior deficits required by the new mental retardation definitions.

2) Throughout the past 20 years, there has been increased emphasis in education on serving individuals' educational needs in the least restrictive environments (LRE) possible. Collaterally, instructional technologies for serving students with diverse learning needs have improved. These changes, coupled with an overriding legal preference for serving students in least restrictive environments appropriate to their needs caused the task force to seriously consider whether most students with intellectual performance in the 75-85 range could not benefit from general education instruction with appropriate modifications. Indeed, many students with intellectual performance in this range already participate in general education environments for all or a large majority of their educational programming.

3) Overrepresentation of students from diverse racial backgrounds has been identified as a problem for over 20 years in classrooms for children with mental retardation. Particularly, overrepresentation of black children in these classes has created significant controversy. The conditions and contributions to this phenomenon are many and complex. The rhetoric surrounding the issue is even more voluminous. For the purposes of this paper, let it suffice to say that mental retardation criteria, based largely on the use of standardized tests of intellectual performance, will identify more black children than white children as having mental retardation. Moreover, the higher the IQ cutting score, the greater the overrepresentation. Thus, Iowa, with its 85 IQ cutoff score was in a situation where its entitlement criteria for mental disabilities could result in greater minority overrepresentation than in most other states.

II. IDENTIFICATION PROCESS

"The major practical objective of identifying problems is to correct them."

Adelman and Taylor, 1993

The identification process is the means by which the educational system identifies those individuals who have a mental disability and require special education in order to benefit from the educational experiences of school. The process has two interrelated phases: General education interventions and the full and individual evaluation. Education agencies also participate collaboratively in the early intervention system with health and human service agencies. For some infants and toddlers, the identification of a mental disability may be an appropriate and necessary first step in accessing early intervention programs and services in a variety of agencies, and will be used in planning transitions to public school programs.

A description of each phase of the process is provided in this section. Each phase is discussed from the perspective of individuals experiencing learning problems; that is, individuals who demonstrate a lack of basic skill development and application, poor achievement, and a lack of academic progress. Each description begins with an overview of the phase, and includes a discussion of the relevant administrative rule and an explanation and elaboration of the phase.

General Education Interventions

"There are three [sic] main purposes of instructional assessment. One purpose is to identify the areas of instructional need; this is the ***direction*** *of instruction. The second is to determine the skills and sequence of skills to be taught; this is* ***starting point*** *of instruction. The third is to ascertain* ***how to*** *deliver instruction. The fourth is to determine whether instruction is succeeding; this permits* ***correction*** *of instruction."*

Lloyd and Blandford, 1991, p 46.

In discussing intervention for individuals experiencing learning problems, Adelman and Taylor (1993) state that "the principle of least intervention needed" should be followed. Applying this principle, they proposed that intervention efforts should first consider whether there is an appropriate match between the learner and the environment, and that "general, enriched and least disruptive solutions" should be tried before embarking on remedial instruction or specialized treatments and settings. Additionally, they stressed that simpler explanations for learning problems should be considered before assuming there is a disability or disorder intrinsic to the learner, and that the pursuit of a disability or disorder should occur only after "simpler explanations have been systematically ruled out." General education interventions reflect this orientation of support for individuals who experience learning problems in school. An emphasis on general education interventions is consistent with three basic premises. First, that not all individuals who experience learning problems have disabilities or require special education. Second, that teachers are active interventionists and have a variety of resources for assisting individuals who are experiencing difficulty in school. Third, that providing early intervention in the general education setting is preferable to waiting for the problem to become so severe that special education services are needed to provide adequate supports. For young children, the early detection of significant learning problems may lead multidisciplinary teams to access services as a preventive measure. Since universal access to general education programs for children younger than five years of age is unavailable, reliance on special education resources to meet individual needs is typical.

Iowa's Administrative Rules

Iowa's Administrative Rules (1995) identify the purpose of general education interventions and describe the basic standards for general education interventions as follows:

> **Purpose:** "to resolve the presenting problem or behaviors of concern in the general education environment prior to conducting a full and individual evaluation" (IAC,281—41.48(2)).

> **Standards:** "General education interventions shall include teacher consultation with special education support and instructional personnel working collaboratively to improve an individual's educational performance. The activities shall be documented and shall include measurable and goal-directed attempts to resolve the presenting problem or behaviors of concern, communication with parents, collection of data related to the presenting problem or behaviors of concern, intervention design and implementation, and systematic progress monitoring to measure effects of interventions" (IAC,281—41.48(2)*b*).

Explanation and elaboration

The following section provides a more detailed description of the purpose and standards of general education interventions presented in Iowa's administrative rules.

> 1) The nature and severity of educational problems varies across individuals. Some problems are minor in degree and require limited effort, time and resources to resolve. In these circumstances, the teacher and parent may be able to successfully address an individual's problem within a short period of time. In some cases, the teacher may be able to resolve the problem through informal consultation with another teacher. Other problems are more complex and severe and require more intense intervention efforts. In such circumstances, the teacher and parents access the assistance and support of other educators in order to address the presenting problems or behaviors of concern of a particular individual. It is in these circumstances—more complex, more severe, more difficult problems—that general education interventions come into play.

> 2) General education interventions are a collaborative effort between the individual, parents, and educators. Active parent participation in general education interventions is a critical ingredient. Parents are invited to participate, included in general education intervention efforts, and informed at all decision making points. This cooperative effort includes general education and special education personnel working together to meet the educational needs of individuals experiencing learning, behavioral or adjustment problems.

> 3) General education interventions are solution-focused. As stated in the purpose, resolution of individual problems or concerns in the general education environment is the focus. In this respect, general education interventions are preemptive efforts to prevent problems from becoming established and more resistant to change.

4) General education interventions are data-driven decision making efforts. The presenting problems or behaviors of concern are described in objective, measurable terms. Baseline data on the problem or behavior is collected and documented. Ongoing, systematic data gathering is conducted to monitor progress and evaluate the impact of the intervention on individual performance. Decisions about changes in the presenting problem or behavior of concern and evaluation of the effects of an intervention are based on data.

5) The data and information gathered to help define and clarify the nature of the problem needs to reflect multiple environments, multiple sources of information, and multiple types of assessments. Assessment procedures need to be selected based on their relevance to the nature of the specific presenting problems or behaviors of concern and their ability to yield information that will help define and clarify the nature of the problem. Setting variables need to be considered as possibly influencing or contributing to the problem or concern. As appropriate to the specific problem or concern, the school and home environment, the classroom environment, the curriculum, classroom instructional methods as well as student characteristics need to be considered.

6) General education interventions are based on a formal systematic written plan that is designed to accommodate or solve a specific individual's presenting problem or behavior of concern. The written plan describes implementation, progress monitoring and evaluation procedures.

7) For infants and toddlers, the early intervention system functions to coordinate the identification process. For some individuals, the need for supports and services are immediate and obvious (e.g., severe, multiple impairments) at a young age. In such cases, health, social service, and education agencies work cooperatively to provide family-centered services and supports. When transition planning begins for entry into preschool programs administered by the education system, the role of general education interventions is again reviewed by the multidisciplinary team.

Importance of general education interventions

If an individual's learning problems are unresponsive to well-designed and well-implemented general education interventions, or if the learning problem requires the continued provision of a substantial effort that is typically not expected of the general education program, then the multidisciplinary team will decide to pursue a full and individual evaluation. This evaluation is the second phase of the identification process. When general education interventions are conducted with integrity, they facilitate the full and individual evaluation in the following ways:

1) Provide baseline data about the individual's primary learning problem(s) and strengths.

2) Provide information about educational interventions that have not resolved the learning problem or that have proven to be useful in improving the individual's skill and performance.

3) Provide data that is necessary to a comprehensive full and individual evaluation.

4) Provide data that directs the development of assessment questions that guide the full and individual evaluation.

Full and Individual Evaluation

Before special education and related services can be provided to an individual, a full and individual evaluation of the individual's educational needs must be completed. The data generated during this phase of the identification process serves two purposes: (a) to generate information that will guide the development and implementation of educational interventions, and (b) to determine whether the individual is entitled to receive special education. Entitlement in this context refers to the requirement that the individual is both eligible for and in need of special education in order to receive an appropriate education.

The full and individual evaluation does not represent an interruption of the general education intervention phase of the identification process. Rather, the evaluation represents a more intense and broader approach to the presenting learning problem. General education interventions can continue during the full and individual evaluation. Since interventions include assessment for the purpose of defining the learning problem and of monitoring the impact of efforts specifically designed to address the learning problem, continued use of general education interventions, or the use of additional or redesigned interventions can be a means for gathering assessment data critical to the decision making process. The relationship between general education interventions and the full and individual evaluation is not like the common "ON-OFF" electrical switch for lighting, but rather is best represented by the variable electrical switch that allows a person to gradually adjust the amount of light. The full and individual evaluation should be considered as a natural extension or progression of general education interventions and not as a separate, disconnected event of unrelated information gathering.

Iowa's Administrative Rules

Iowa's Administrative Rules (1995) identify the purpose of the full and individual evaluation and describe the basic standards for the full and individual evaluation as follows:

> **Purpose:** "to determine the educational interventions that are required to resolve the presenting problem, behaviors of concern, or suspected disability, including whether the educational interventions are special education" (IAC,281—41.48(3)).
>
> **Standards:** "A full and individual evaluation shall include:
>
> 1) An objective definition of the presenting problem, behaviors of concern, or suspected disability.
>
> 2) Analysis of existing information about the individual, including the results of general education interventions.
>
> 3) Identification of the individual's strengths or areas of competence relevant to the presenting problem, behaviors of concern, or suspected disability.
>
> 4) Collection of additional information needed to design interventions intended to resolve the presenting problem, behaviors of concern, or suspected disability, including, if appropriate, assessment or evaluation of health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, adaptive behavior, and motor abilities. (281—41.48(3)*a*).
>
> Additionally, the full and individual evaluation must be conducted by a multidisciplinary team." (IAC,281—41.48(3)*b*)

Explanation and elaboration

The following section provides a more detailed description of the purpose and standards of a full and individual evaluation as presented in Iowa's administrative rules.

1) The assessment activities of the full and individual evaluation need to be guided by a clear, precise description of the learning problem. Information from general education interventions should be used in defining the nature and parameters of the presenting learning problem.

2) Screening data about sensory or health problems that may be contributing to or sustaining the learning problem should be considered by the multidisciplinary team in defining the presenting learning problem. Some, if not all, of this data may have been gathered during the general education intervention phase. If possible sensory or health concerns were not addressed during general education intervention efforts, then the multidisciplinary team should address the sensory and health areas as a part of the effort of defining the presenting learning problem.

3) Similarly, the multidisciplinary team should confirm that the learning problem has persisted across time and consider whether the individual's poor academic performance can be attributed to an inconsistent educational program or inappropriate instruction. Most, if not all, of the information necessary to address these concerns should have been gathered during the general education intervention phase. If not, the multidisciplinary team should gather such information as a part of the effort to describe the presenting learning problem.

4) Selection of assessment tools and procedures for the full and individual evaluation should be based on the data necessary for the multidisciplinary team to understand the nature and extent of the learning problem. The information collected through the full and individual evaluation should (a) include multiple sources (direct and indirect assessment, different individuals) and types of data (quantitative and qualitative); (b) address all relevant skill and performance areas; and (c) consider all relevant environmental factors.

5) The assessment activities of the full and individual evaluation should yield information that (a) identifies an individual's strengths as well as weaknesses; and (b) assists in determining the types of instructional modification or accommodations the individual might require.

Entitlement Decision

As this phase of the identification process comes to closure, an intervention plan will be developed and the multidisciplinary team will determine whether the individual is entitled to special education. As noted earlier, entitlement has two components: eligibility and need. The eligibility component requires the multidisciplinary team to answer "the question of whether an individual has an educational disability or not. It is a dichotomous decision. The determination of eligibility should not be equated with entitlement. The individual must be both eligible for and in need of special

education in order to be entitled" (Iowa Directors of Special Education Association, January 1996, p. 4).

> "The need component of an entitlement decision answers the question of whether an individual requires special education in order to receive a free appropriate public education.....having a disability alone was not sufficient to confer special education entitlement on an individual. The individual must also need special education in order to be entitled. Educational need has been defined in many ways, but the minimum standard relates to an individual's ability to successfully pass from grade to grade. Empirically, an individual's needs can be defined operationally as a discrepancy between her/his current level of educational performance and the expectations of the individual's educational environment. Additionally, documentation of an individual's inability to benefit significantly from reasonable general education interventions or accommodations can also be used to demonstrate need for special education" (Iowa Directors of Special Education, January 1996, p. 5).

If the multidisciplinary team finds that the individual is both eligible and entitled to special education services, the team would develop and implement an individualized education program (IEP). If the team determines that the individual is eligible but is not in need of special education services, an intervention plan should still be developed and implemented (e.g. "Section 504 plan," I-PLAN) which delineates how the individual's needs are to be accommodated within the general education setting.

Throughout the identification process, multidisciplinary teams should be guided by specific assessment questions relevant to instructional planning and which provide the information needed to make decisions concerning how best to meet an individual's needs. As teams answer assessment questions and gather assessment data throughout the identification process, best practices in assessment should be considered and implemented. The following section, *Assessment and Decision Making*, provides a description and discussion of general assessment standards and practices and makes recommendations for best practice.

III. ASSESSMENT AND DECISION MAKING

Assessment Practices

The full and individual evaluation process must provide information that enables the multidisciplinary team to make a variety of decisions that link individual needs to an appropriate level and type of support services and provide an ongoing evaluation of individual performance with respect to specific goals. Simply documenting an individual's current performance deficits is insufficient. It is recommended that assessment efforts be focused primarily on evaluating the individual's current level of educational performance and adaptive behavior skills. Assessment procedures conducted in these two areas provide information that can be linked directly to intervention decisions.

Throughout the identification process, multidisciplinary teams should be guided by specific assessment questions relevant to instructional planning and which provide the information needed to make decisions concerning how best to meet an individual's needs. As teams answer assessment questions and gather assessment data throughout the identification process, best practices in assessment should be considered and implemented. The following minimal standards are provided to guide the selection of assessment tools and decision making throughout the evaluation process:

1) The purpose for assessment needs to be clearly articulated and understood by all individuals involved.

2) Assessment is a solution-focused process with the purpose of searching for answers to well-defined questions and not solely determining a condition or classification.

3) The limitations of assessment tools and procedures and the tentative nature of conclusions based on data from these tools and procedures, need to be clearly stated and understood by all individuals in the assessment and decision making process.

4) Assessment tools and procedures must meet generally accepted standards of technical adequacy of reliability and validity for decision making about individuals.

5) Assessment tools and procedures need to be culturally, racially, and linguistically unbiased.

6) Assessment needs to be multifaceted and include:
- —multiple data sources (e.g., teachers, parents, students, and other service providers familiar with the student).
- —multiple types of data (e.g., qualitative and quantitative).
- —multiple types of tools and procedures (e.g., standardized measures and alternative methods of assessment).
- —multiple environments (e.g., classrooms, home, work, and community settings).

7) Assessment needs to consider performance across time, not just data from a single point in time. Assessment should be viewed as an information-gathering process that occurs across time rather than an isolated, time-bound event.

8) The assessment process involves the systematic collection of meaningful, relevant information about an individual's performance.

9) The assessment process must provide prescriptive information and include documentation of an individual's strengths as well as weaknesses. Prescriptive assessment measures must be conducted to meet the requirements of the *Iowa Administrative Rules of Special Education* (1995) in the determination of mental disability. These assessment procedures will focus primarily on the individual's current level of educational performance and adaptive behavior skills.

10) It is critical to evaluate the individual's performance within the context of his, or her, current environment.

11) Significantly subaverage intellectual functioning is descriptive of an individual's behavior across many different settings and situations. The assessment of intellectual functioning must include a variety of information sources; and the determination of a mental disability is the responsibility of the entire multidisciplinary team.

12) In addition to standardized measures, alternative methods for acquiring information on the individual's performance in academic domains must be incorporated into the assessment process. Information from alternative assessment techniques (e.g., work products, curriculum-based measures) provide data that can be linked directly to intervention planning.

13) The assessment of adaptive behavior must include direct measures (e.g., informal and structured observations), as well as indirect measures (e.g., third-party interviews and rating scales), to evaluate the individual's performance in comparison to same-age peers from similar cultural backgrounds.

14) Decision making about an individual is based upon the professional judgment of the multidisciplinary team with consideration of both quantitative and qualitative data about an individual's performance.

There are a number of factors to be considered regarding the collection of data during the assessment process. First, the type of data collected must match the purpose of assessment. Second, practitioners must collect a sufficient amount of data to answer questions in a reasonable, responsible manner. Third, the quality of the data must be considered. In this respect, the data collected during assessment must enable practitioners to make valid decisions. Finally, the results of the assessment process must provide guidance for professional judgment. Another dimension of assessment is the determination of what constitutes a significant deficit in a given area. The criteria for deficits will vary depending on the assessment methodology and the specific question that is being addressed. Different assessment methods use different units of measurement, thus, the standard for a significant deficit may vary across procedures. For example, deficits can be based on standardized tests, developmental levels, medical standards, curricular expectations, community standards, and the criteria for successful performance in future environments (e.g., kindergarten for preschoolers, vocational settings for secondary aged students). A variety of assessment methods are used to gather data for decision making (NASP, 1994). Each of these

procedures can be used descriptively to establish current levels of individual performance, or prescriptively to address questions regarding strategies to improve individual performance. A broad categorization of these methods is as follows:

Review of records refers to the process of collecting and evaluating existing information that is relevant to assessment questions. This information may include grades, attendance records, classroom assignments, previous assessment results, previous intervention outcomes, and medical records.

Interview refers to the process of direct communication with the student, family members, and professionals to collect information regarding individual behavior across situations and settings.

Observation refers to the process of systematically collecting information about behaviors across situations and settings by watching and recording events. Observations can focus on both individual performance and the environmental variables that surround the behavior of interest (e.g., instructional support).

Test and ratings refers to standardized instruments used for obtaining a sample of behavior. Tests may include norm-referenced measures, standardized methods for curriculum-based measurement, or performance-based assessments. Ratings include checklists and standardized forms completed by the student, parent, and teacher.

Multicultural Issues

The overrepresentation of minorities in special education is well documented, and overrepresentation of black students in mild mental retardation programs continues to be problematic (Reschly & Ward,1991). Reschly and Ward examined the representation of black students in Iowa programs for mild mental retardation and evaluated the extent to which adaptive behavior deficits were considered in eligibility and placement decisions. This investigation yielded the following results:

1) Black students were overrepresented in programs for individuals with mild mental retardation in Iowa and nationally.

2) Classification of individuals as mildly mentally retarded was based primarily on IQ scores.

3) Neither black nor white children received an adequate assessment of adaptive behavior.

A major consideration in the overrepresentation of black students is the potential impact of economic deprivation. Reschly and Ward (1991) noted that the classification of students with mild mental retardation (but not more severe deficits) is more common in poverty circumstances, regardless of race. Many members of ethnic minority groups experience economic disadvantages, and the consequences of poverty on maternal and child health may be related to school failure (Sattler, 1988).

The increasing prevalence of diverse ethnic groups in America's schools means that bilingualism may be a relevant factor with respect to individual performance. Low scores on verbal scales in IQ tests and educational measures may reflect inexperience with words, ideas, and grammatical structures, rather than deficits in general ability or academic competence (Sattler, 1988).

In general, the categorical eligibility model for determining access to services has led to a variety of concerns (NASP, 1994). First, many measures used to determine eligibility have not been demonstrated to be reliable and valid for that purpose. This concern is particularly relevant for individuals who are racially, culturally, or ethnically diverse. Second, the conception of disability within the individual presents a significant problem for identifying students, particularly students of color, as disabled. Finally, an emphasis on categorical eligibility requirements may limit a more thorough evaluation of supports that enable individuals to demonstrate competence. Hehir (T. Hehir, personal correspondence, May 17, 1995) provided the following commentary with respect to categorical placements.

> The practice of 'labeling' children according to their category of disability may result in inappropriate removal of disabled children to segregated educational environments without appropriate consideration of whether each child could achieve satisfactory educational benefits by being educated with nondisabled peers, with the assistance of supplemental aids and services.

IV. DETERMINING AND DOCUMENTING ELIGIBILITY

Definition of Mental Disability

The *Iowa Administrative Rules of Special Education* (1995) provides the following definition of mental disability:

> "Mental disability means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects an individual's educational performance."

The determination of a mental disability is dependent on the student meeting **all four** of these criteria:

1. Significant subaverage general intellectual functioning

2. Concurrent deficits in adaptive behavior

3. Deficits manifested during developmental period

4. Adverse effects on educational performance.

The following sections provide a brief discussion of the constructs included in each component of the definition, considerations in the assessment of each component, recommendations for preferred assessment practices, and criteria for determination of eligibility.

Intellectual Functioning

Conceptual framework

Definitions of intelligence, in general, emphasize the ability to adjust or adapt to the environment, ability to learn, and/or the ability to perform abstract thinking (Sattler, 1988). However, the general public often considers social competence to be an important component of intelligence. Social competence has been described as consisting of two constructs (Greenspan & Granfield, 1992): practical intelligence and social intelligence. Practical intelligence refers to the individual's ability to perform daily living skills, such as are typically sampled in adaptive behavior measures. Social intelligence refers to a person's ability to understand and deal effectively with social and interpersonal objects and events. Since environmental demands, and the skills needed to cope with those demands, vary across contexts and locations, cultures may also vary with respect to the expectations of individual competence within the community. Thus, an important consideration in the determination of mental disability is the identification of needed supports for the individual to succeed in socially relevant contexts (Greenspan,1995).

Considerations

The limitations of IQ tests as a measure of intelligence have been extensively discussed in the professional literature (National Research Council, 1996). First, such tests provide only an estimate,

at one point in time, of an individual's performance. Second, although test results may predict performance in an educational setting, they have limited validity in predicting competence in other relevant contexts. The information in IQ tests does not relate sufficiently to what people do in their practical, everyday environments. For example, children are often diagnosed with a mental disability only when they enter the public school system, and may not be viewed as having a mental disability outside the school setting. Finally, there is the assertion that intelligence tests are racially and culturally biased. This has led African American parents to seek protection from the use of intelligence tests to place their children in special education classes (Larry P. v. Riles, 1992).

Recommendations

Reschly and Grimes (1995) provided the following recommendations with respect to a best practices approach in the assessment of intellectual functioning. First, IQ tests should only be used when the results are directly relevant to well-defined referral questions and other information does not address those questions. Mandatory use of such measures for all referrals is not consistent with best practices. Second, intellectual assessment must be part of an individualized and multifactored approach to identifying individual needs. Third, reporting and interpretation of standardized intellectual assessment instruments must reflect the known limitations and technical characteristics of the test. Fourth, interpretation of test performance must reflect a consideration of the individual's overall strengths and weaknesses across other relevant dimensions of behavior.

In the case of very young children with a medical diagnosis of a genetic condition (e.g., Down Syndrome), intellectual assessment may not demonstrate significant deficits until certain stages of development are reached. When a medically diagnosed condition includes a documented prognosis of mental disability that cannot be immediately verified, parents can be advised of the likelihood of their child's future performance on measures of intellectual functioning and the purpose of special education in providing early intervention services and supports.

With respect to the determination of mental disability, **significantly subaverage intellectual functioning is descriptive of an individual's behavior across many different settings and situations. The assessment of intellectual functioning must include a variety of information sources, and the determination of a mental disability is the responsibility of the entire multidisciplinary team.**

Eligibility

The results of a full and individual evaluation must answer the question: Are there significant deficits in intellectual functioning and adequately documented deficits via alternative measurement procedures? With respect to standardized, nationally-normed measures of intellectual functioning, subaverage general intellectual functioning is determined by a full scale IQ score of 75 or less.

If significant deficits are identified, then the individual meets this criterion for mental disability. If the individual does not display significant deficits in intellectual functioning, then the student does not meet this criterion for mental disability. In this case, the multidisciplinary team must return to general education interventions for resolution of the presenting concern.

Conceptual framework

In everyday use, adaptive behavior generally implies the achievement of skills needed for successful performance in typical environments (Bruininks, Thurlow, & Gilman, 1987). These skills are encompassed within two broad domains. The first is personal skill development, which includes the skills needed for self-care, home living, work, and recreation. The second is social competence, which involves the behaviors needed to interact appropriately with others in the community. Both of these areas encompass multiple skills that are expected at different age levels (Birth to 6 years, 6 - 13 years, and 14 - 21 years). The construct of adaptive behavior has been characterized as involving multiple elements (Harrison & Robinson, 1995) including (a) developmental changes, in that skills increase in number and complexity as individuals grow older; (b) multiple domains, including skill areas such as self-help, vocational, leisure and recreation (AAMR, 1992); (c) expectations and standards of other people in the individual's family, community, and culture; (d) demands of specific situations and environments, such as home, school, community, and workplace; and (e) discrepancies between acquired skills and the functional performance of those skills in specific situations. The concept of adaptive behavior has been incorporated into broader models of general competence (Greenspan & Granfield,1992). For example, Greenspan's (1995) definition of mental retardation noted that limitations in intellectual functioning cause an individual to have ongoing need for supports to succeed across activities that are typically associated with adaptive skills, including educational, work, and self-care activities.

Adaptive behavior as a criterion for mental retardation was adopted by the American Association on Mental Deficiencies-AAMD (now titled the American Association on Mental Retardation-AAMR) over 30 years ago (Heber, 1961). The current AAMR (1992) definition is accompanied by the assumption that adaptive skills must be considered in the context of environments that are typical of the individual's age-peers, and in relation to the individual's needs and supports within the environment. It also asserts that limitations may coexist with strengths, and that an individual's functioning is likely to improve if appropriate supports are provided.

Considerations

The inclusion of adaptive behavior deficits as a criterion for the determination of mental retardation has led to the development of a number of norm-referenced rating scales. These scales have attempted to provide a measure of the individual's adaptive behavior in comparison to same-age peers. Historically, adaptive behavior scales have often been used only as a supplementary source to intelligence tests in the assessment of mental disabilities. Adaptive behavior scales have a number of limitations (Harrison & Robinson, 1995). First, third-party reporters may have a limited knowledge of the individual's skills and performance across areas and settings. Second, the reporter's general perception of the individual's adaptive behavior may not provide sufficiently detailed information regarding specific skills. Third, norm-referenced measures may not provide an adequate representative sample of relevant adaptive behaviors. Fourth, normative samples may not provide an adequate comparison group for specific individuals.

Recommendations

Standardized, nationally-normed rating scales may constitute one component of adaptive behavior assessment. However, given the inherent limitations in many currently available measures and the importance of assessing adaptive behavior for decision making, a single measure of adaptive behavior is inadequate. Practitioners need to include alternative methods of assessment in order to obtain ecologically valid information about the individual's relative strengths and weaknesses. For infants and toddlers, criterion-referenced measures are an important source of information in the assessment of developmental progress.

The focus of evaluating adaptive behavior domains must emphasize relevant skill areas at different age levels (Bruininks, Thurlow, & Gilman,1987). The assessment of selected adaptive behavior skill areas, and the specific skills within each area, will be dictated by the age of the individual. Assessment procedures should provide information regarding a) the degree and pervasiveness of deficits across domains; b) the type and level of support service needed to improve individual performance; and c) family input regarding individual goals, with the ultimate objective being the emergence of the individual as an independent, productive citizen in his, or her, community.

The following table provides a breakdown of AAMR (1992) adaptive skill areas across different ages.

Birth - 6 years	**6 - 13 years**	**14 - 21 years**
Communication	Communication	Communication
Self-care	Self-care	Self-care
Social skills	Social skills	Social skills
Physical development*	Home living	Home-living
	Community use	Community use
	Self-direction	Self-direction
	Health and safety	Health and safety
	Functional academics	Functional academics
	Leisure	Leisure
		Work

*Bruininks, Thurlow & Gilman (1987)

Harrison and Robinson (1995) provided the following recommendations in the assessment of adaptive behavior. First, adaptive behavior assessment should be planned to answer specific questions regarding the individual's functioning and service needs. Second, multidisciplinary teams should include both direct and indirect measures as a means of gathering important information on the individual's adaptive behavior skills. Direct measures include informal and structured observations of the individual's performance in relevant contexts. Indirect measures include self-reports, sociometric procedures, and informal interviews. Third, multidisciplinary teams must give a balanced consideration to adaptive behavior information along with intellectual and academic achievement assessment results in the determination of mental disability. Finally, the most recent

AAMR (1992) document prescribes that multidisciplinary teams expand assessment to include the identification of supports and services that are consistent with adaptive skill needs and select interventions that promote independence across settings. For example, Reschly (1990) emphasized the importance of addressing both in-school skills and out-of school skills in the assessment of adaptive behavior. **An adaptive behavior assessment must include direct measures (e.g., informal and structured observations) as well as indirect measures (e.g., third-party interviews and rating scales) that evaluate the individual's performance in comparison to same-age peers from similar cultural backgrounds.**

Eligibility

The results of a full and individual evaluation must answer the question: Are there significant and adequately documented deficits in two or more areas of adaptive behavior? With respect to standardized, nationally-normed measures of adaptive behavior, significant deficits means the individual scores at least one standard deviation below the mean across two or more adaptive behavior domains. Discrepancies may also be confirmed via alternative assessment measures that adequately document discrepancies in two or more adaptive skill areas. Alternative assessment measures must compare the individual's performance to the performance of nondisabled peers from the same cultural background.

If deficits are identified in two or more adaptive skill areas, then the individual meets this criterion for mental disability. If the individual does not display deficits in two or more adaptive skill areas, then the individual does not meet this criterion for mental disability. In this case, the multidisciplinary team must return to general education interventions for resolution of the presenting concern.

Developmental Period

Considerations

Developmental period refers to the age span from birth to age 21. In the majority of cases, the term mental disability refers to a pattern of performance that endures for more than one year. It is recognized that in cases where student needs are sufficiently immediate and obvious (e.g., severe multiple impairments), extended assessment may not be necessary in order to determine a mental disability.

Eligibility

The results of a full and individual evaluation must answer the question: Are deficits manifested during the developmental period? With respect to the determination of the onset of mental disability during the individual's developmental period, discrepancies can be documented from birth to age 21, with the general guideline that discrepancies endure for more than one year. Exceptions to the latter provision are appropriate in the following cases:

1) Diagnosis of genetic etiology and/or multiple impairments provides clear and compelling evidence of an individual's need for services.

2) For infants, toddlers and preschoolers, in circumstances where differential diagnosis is uncertain, if the individual's need for services is clearly documented, then it is appropriate to implement early intervention services.

3) Since 1991, federal legislation (P.L.102-119, Amendments to the Individuals with Disabilities Education Act) has permitted the provision of special education and related services to children aged birth through 5 years with developmental delays. The U. S. Office of Special Education and the Iowa Department of Education, Bureau of Special Education (Clary, 1991) have determined that categorical identification of disability is not required to provide special education and related services to children aged birth through 5 years. Area education agencies may identify and report children with significant developmental delays who are in need of special education as noncategorical (NC), Individuals Requiring Special Education (IRSE), or as Eligible Individuals (EI).

If deficits are manifested during the developmental period, then the individual meets this criterion for mental disability. If deficits are not manifested during the developmental period, then the individual does not meet this criterion for mental disability.

Educational Performance

Conceptual framework

Traditionally, the assessment of educational performance has been used to determine whether an individual is (a) eligible and(b) in need of special education services to receive an appropriate education. The eligibility question is typically addressed by assessment measures that describe the individual's academic performance in relation to same-age peers (e.g., standardized tests). In the determination of eligibility, multidisciplinary teams must establish substantial and pervasive discrepancies between the individual's performance and expectations in the educational environment. Furthermore, discrepancies must be identified in core academic areas (reading, math, language arts, and science) in comparison to same-age peers in the general education program. For infants, toddlers, and preschool aged children, educational performance is reflected in the dimensions of developmental functioning as they relate to expectations for future academic achievement.

Descriptive measures are useful to the extent that they establish a current level of individual performance on specific tasks. However, such measures provide minimal information with respect to individual performance across curricular tasks in the educational setting, and little guidance about which instructional materials or strategies are needed to promote individual learning. A comprehensive evaluation of individual academic needs requires the use of functional assessment procedures. Functional assessment refers to an evaluation of the skills the individual requires to complete tasks independently, and the conditions under which the individual must perform those skills (Berg, Wacker, & Steege,1995). The primary advantage of functional assessment procedures is that the information can be used to facilitate individual learning. Functional assessment information is particularly useful to multidisciplinary teams in determining whether the individual's needs can be met within general education settings.

Considerations

Traditionally, nationally-normed tests have been used in the identification of mental retardation. Salvia and Ysseldyke (1991) presented a number of cautions with respect to the use of standardized achievement tests in the assessment of educational performance. First, practitioners need to be aware of the overall technical adequacy of the various measures used in evaluating educational performance. These authors reported that even purported diagnostic tests lack the needed technical characteristics to make specific instructional decisions. Second, the use of standardized tests may provide little information on the problem-solving strategies the individual used to complete test items. Finally, consideration must be given to the relative match between test content and the actual curriculum. If the test does not contain curricularly relevant material, then the results of the assessment are meaningless. Given these limitations, **alternative methods for acquiring information on the child's performance in academic domains must be included in the assessment process.**

Recommendations

The assessment of educational performance must be tailored to validate a demonstrated need for special education supports in order for the individual to meet the demands of the educational environment. A first step is to document resistance to intervention efforts and reasonable accommodations within the general education curriculum. Multidisciplinary teams must ensure that special education is not provided merely as a substitute for inadequate general education instruction. Second, assessment procedures must capture the individual's performance in his or her local school or community setting. Assessment procedures that provide curricularly relevant information include curriculum-based assessment, work samples, and individual classroom performance over time. The assessment of an individual's performance in comparison to other norms or standards is done only if that appears to have utility for decision making. For infants, toddlers, and preschool aged children, developmental delays can be examined in depth via criterion referenced measures. Third, an individual's educational needs must be considered within the broader context of natural environments in which the individual participates (National Association of School Psychologists, 1994), including home, community, and vocational settings. **It is critical to evaluate the individual's performance in the context of his or her current environment.**

Eligibility

The results of a full and individual evaluation must answer the question: Are there significant and adequately documented deficits in all core areas of the educational curriculum? Determination of eligibility must be based on documentation of generalized low performance across all core academic areas. Core academic areas include math, reading, language arts, and science, with other academic areas included as needed to guide decision making. With respect to standardized, nationally-normed achievement measures, significant deficits means the individual scores at least one standard deviation below the mean. Standardized measures must be further validated by in-school data that documents differences between the individual's performance and the performance of same-age peers from the same cultural background. Assessment of academic performance must also include documentation of resistance to general education interventions. The assessment process will provide confirmation of the pervasiveness and severity of academic deficits. For infants, toddlers, and

preschoolers, assessment must document significant deficits in two or more developmental areas including cognitive, language, social/emotional, self-care, and fine/gross motor skills.

If deficits are identified in all core academic areas, then the individual meets this criterion for mental disability. If the individual does not display deficits in all core academic areas, then the individual does not meet this criterion for mental disability. In this case, the multidisciplinary team must return to general education interventions for resolution of the presenting concern.

V. ENTITLEMENT

Entitlement Decision

As the eligibility phase of the identification process comes to closure, an intervention plan will be developed and the multidisciplinary team will determine whether the individual is entitled to special education. Entitlement has two components: eligibility and need. The eligibility component requires the multidisciplinary team to answer the question of "whether an individual has an educational disability or not. It is a dichotomous decision. The determination of eligibility should not be equated with entitlement. The individual must be both eligible for and in need of special education in order to be entitled" (Iowa Directors of Special Education Association, January, 1996, p. 4).

"The need component of an entitlement decision answers the question of whether an individual requires special education in order to receive a free appropriate public education . . having a disability alone is not sufficient to confer special education entitlement on an individual. The individual must also need special education in order to be entitled. Educational need has been defined in many ways, but the minimum standard relates to an individual's ability to successfully pass from grade to grade. Empirically, an individual's needs can be defined operationally as a discrepancy between his, or her, current level of educational performance and the expectation of the individual's educational environment. Additionally, documentation of an individual's inability to benefit significantly from reasonable general education interventions or accommodations can also be used to demonstrate need for special education" (Iowa Directors of Special Education Association, January, 1996, p. 5).

If the multidisciplinary team finds that the individual is both eligible and entitled to special education services, the team would develop and implement an individualized education program (IEP) in cooperation with the individual and his or her family. If the team determines that the individual is eligible but is not in need of special education services, an intervention plan should still be developed and implemented (e.g., "Section 504 plan", I-PLAN) which delineates how the individual's needs are to be accommodated within the general education setting.

Intervention Planning

The assessment procedures that are used to answer questions about individual performance are embedded within a systematic problem solving process that includes the gathering of prescriptive assessment data. This approach has important implications with respect to the outcomes of assessment. It represents a movement toward a supports-based framework in which assessment results are directly linked to individualized intervention and services. AAMR (1992) recommends that assessment includes an evaluation of the types and intensities of supports that enable the individual to succeed in his or her current educational settings. These supports may vary across a number of dimensions. First, supports may be limited to specific adaptive skills areas, type of services, or settings. Second, supports may range from time-limited (short term interventions) to ongoing, long term programming. Third, intensities of support may vary across individuals and may change during the person's life cycle. Finally, supports may vary with respect to the number of

personnel needed to implement interventions and services. AAMR (1992) descriptions of intensities of support are categorized across the following four levels:

1) Intermittent: Supports on an "as needed basis." Short term supports needed during life span transitions (e.g., beginning kindergarten, job loss).

2) Limited: Characterized by consistency over a time-limited basis (toilet training, time limited employment training, transitional supports).

3) Extensive: characterized by regular involvement (daily) across some environments and not time-limited (e.g., facilitation of participation in classroom activities, long term home living support).

4) Pervasive: Characterized by constant, high intensity support across environments, and may include potentially life-sustaining measures.

VI. APPENDICES

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AAMR Adaptive Behavior Skill Areas

The AAMR (1992) provides the following list of adaptive behavior skill areas with the inclusion of physical development as a recommended category (Bruininks, Thurlow, & Gilman, 1987).

1. *Communication:* Skills include the ability to comprehend and express information through symbolic behaviors (e.g., spoken word, written word/orthography, graphic symbols, sign language, manually coded English) or nonsymbolic behaviors (e.g., facial expression, body movement, touch, gesture). Specific examples include the ability to comprehend and/or receive a request, an emotion, a greeting, a comment, a protest, or rejection. Higher level skills of communication (e.g., writing a letter) would also relate to functional academics.

2. *Self-Care*: Skills involved in toileting, eating, dressing, hygiene, and grooming.

3. *Home Living*: Skills related to functioning within a home, which include clothing care, housekeeping, property maintenance, food preparation and cooking, planning and budgeting for shopping, home safety, and daily scheduling. Related skills include orientation and behavior in the home and nearby neighborhood, communication of choices and needs, social interaction, and application of functional academics in the home.

4. *Social Skills:* Skills related to social exchanges with other individuals, including initiating, interacting, and terminating interaction with others; receiving and responding to pertinent situational cues; recognizing feelings; providing positive and negative feedback; regulating one's own behavior; being aware of peers and peer acceptance; gauging the amount and type of interaction with others; assisting others; making choices; sharing; understanding honesty and fairness; controlling impulses, conforming conduct to laws; violating rules and laws; and displaying appropriate sociosexual behavior.

5. *Community Use:* Skills related to the appropriate use of community resources, including traveling in the community; grocery and general shopping at stores and markets; purchasing or obtaining services from other community businesses (e.g., gas stations, repair shops, doctor and dentist's offices); attending church or synagogue; using public transportation and public facilities, such as schools, libraries, parks and recreational areas, streets and sidewalks; attending theaters; and visiting other cultural places and events. Related skills include behavior in the community, communication of choices and needs, social interaction, and the application of functional academics.

6. *Self-Direction:* Skills related to making choices, learning and following a schedule; initiating activities appropriate to the setting, conditions, schedule, and personal interests; completing necessary or required tasks; seeking assistance when needed; resolving problems confronted in familiar and novel situations; and demonstrating appropriate assertiveness and self-advocacy skills.

7. *Health and Safety:* Skills related to maintenance of one's health in terms of eating; illness identification, treatment, and prevention; basic first aid, sexuality, physical fitness; basic safety considerations (e.g., following rules and laws, using seat belts, crossing streets, interacting with strangers, seeking assistance); regular physical and dental check-ups; and personal habits. Related

skills include protecting oneself from criminal behavior, using appropriate behavior in the community, communicating choices and needs, participating in social interactions, and applying functional academics.

8. *Functional Academics:* Cognitive abilities and skills related to learning at school that also have direct application in one's life (e.g., writing; reading; using basic practical math concepts; basic science as it relates to awareness of the physical environment and one's health and sexuality; geography; and social studies). It is important to note that the focus of this skill area is not on grade-level academic achievement but, rather, on the acquisition of academic skills that are functional in terms of independent living.

9. *Leisure:* The development of a variety of leisure and recreational interests (i.e., self-entertainment and interactional) that reflect personal preferences and choices and, if the activity will be conducted in public, age and cultural norms. Skills include choosing and self-initiating interests, using and enjoying home and community leisure and recreational activities alone and with others, playing socially with others, taking turns, terminating or refusing leisure or recreational activities, extending one's duration of participation, and expanding one's repertoire of interests, awareness, and skills. Related skills include behaving appropriately in the leisure and recreation setting, communicating choices and needs, participating in social interaction, applying functional academics, and exhibiting mobility skills.

10. *Work:* Skills related to holding a part or full-time job or jobs in the community in terms of specific job skills, appropriate social behavior, and related work skills (e.g., completing of tasks; awareness of schedules, ability to seek assistance, take criticism, and improve skills; money management, financial resources allocation, and the application of other functional academic skills; and skills related to going to and from work, preparation for work, management of oneself while at work, and interaction with coworkers).

11. *Physical development* (Bruininks, et al., 1987) includes the development of both gross motor and fine motor skills. Basic gross motor skills involve the independent movement of limbs, competence in moving into and out of various positions (e.g., standing, sitting), and the development of a means of mobility. Fine motor skills involve the rudimentary use of reach, grasp, and release; the functional use of objects by means of coordinated movement; and the skillful manipulation of objects in the environment to complete tasks (e.g., using writing utensils, scissors).

Glossary of Terms

A number of the terms used in this document are used differently across different individuals and contexts. The following section explains how they are used within this document. Definitions were taken directly from NASP (1994).

Assessment: Assessment refers to the "process of collecting data for the purpose of (1) specifying and verifying problems, and (2) making decisions about students" (Salvia & Ysseldyke, 1991, p. 3).

Interventions: Interventions are a type of specific supports designed to meet specific needs of children. Interventions can include activities to increase children's competence and skills. They can also include environmental or instructional modifications designed to facilitate the acquisition of such skills. A classroom placement alone (e.g., self-contained classroom) is not an intervention.

Problem Solving: Refers to a systematic process that includes the assessment of children and their environments, identification of needs, development and implementation of supports to meet needs, and the monitoring and evaluation of outcomes.

Professional Judgment: Refers to the adherence to high standards, based on research, and informed practice, that are established by professional organizations (Katz, 1984).

Services and Service Delivery: Refers to assistance provided by professionals. They also refer to the manner in which assistance/interventions are organized school-wide or district-wide.

Special Education: Special education is "specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a child with a disability." [20 U.S.C. Chapter 33 & 1401 (a)(16)] . Special education is not considered an intervention, nor is special education a place or teacher. It should be noted that many supports, services, and interventions to address students' needs are provided outside of a special education system.

Students' Needs: This term is used in the broadest sense in this document. They could include students' needs for increased competence and skills in many domains, including academic, social behavioral, community living, and other areas. They could also include the need for environmental or instructional modifications to promote academic, social and life skills attainment. This term also incorporates the need for educational services that are responsive to individual and cultural diversity.

Supports: Supports are defined broadly to include any assistance which enables children to increase their competence and have their needs met. Supports include professional services and collaboration, environmental and instructional modifications and accommodations, interventions, adapted curriculum, physical assistance, social support, behavioral support, friendship facilitation, equipment and materials.